much power. In recent years, presidential power has grown at the expense of congressional authority.

The version that passed the House is also weak on controlling wasteful tax loopholes. It defines ''targeted tax benefits'' as tax loopholes that benefit 100 or fewer taxpayers. Tax benefits cost us as much as $400 billion per year, but this definition of tax benefits does not even begin to scratch the surface of the problem. I voted for a broader definition which would have allowed targeting any tax provision giving ''different treatment to a particular taxpayer or limited class of taxpayers''. This was the definition contained in the GOP's ''Contract With America.'' Most tax benefits are worthy, but some can be wasteful and costly.

This bill now goes to the Senate for consideration, where Senators of both parties have expressed reservations about its constitutionality, as well as its limited effect on tax loopholes and deficit reduction. These concerns may be addressed in the Senate. I want to vote for a tough line-item veto that will stand the test of time.

LIMITATIONS

A line-item veto can help eliminate government waste, but it is easy to overestimate its effectiveness. The only kind of spending a line-item veto applies to is discretionary spending, not those parts of the budget that have increased most dramatically—entitlements and interest on the debt. Discretionary spending is the area of the budget that has been held most in check. As a share of total federal spending it has fallen from 44% in 1985 to 36% this year. The line-item veto is less about deficit reduction than responsible spending policy.

CONCLUSION

Depsite its drawbacks, a line-item veto can be a useful tool in eliminating wasteful spending and tax loopholes. The tough version I have supported would achieve this without resulting in a dangerous shift of power to the President.

TRIBUTE TO DR. JOEL FRANKEL

HON. PETER DEUTSCH

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 22, 1995

Mr. DEUTSCH. Mr. Speaker, I rise today to honor Dr. Joel Frankel for his outstanding contributions to his community and his profession.

The Concordia Chapter of the City of Hope, National Medical Center, and the Beckman Research Institute have chosen to present their annual Spirit of Life Humanitarian Award to Dr. Frankel for his over 25 years of outstanding commitment to the people of Broward County, and to the science of medicine.

Dr. Frankel was born and raised in Israel. Following service in the Israeli Army, he moved to New York City to pursue higher education. He graduated magna cum laude from Adelphi University, and went on to study medicine at the State University of New York.

Following his graduation from medical school, he spent 5 years at Mount Sinai Medi-

Frankel is a founder and chairman of the board of the Florida Institute of Health. FIH is a rapidly growing multispecialty group practice that began in 1993 and currently is composed of 50 physicians and serves approximately 70,000 patients.

Dr. Frankel and his wife Ellen have been married for 27 years, and they have 2 children, Michael, 21; and Stacy, 17.

Dr. Frankel's contributions to his community make him eminently worthy of the award being bestowed upon him. City of Hope, one of America's foremost medical and research centers, is dedicated to patient care, education, and research in leukemia and other cancers, diseases of the heart, lung, blood, and basic studies in genetics, the neuroscience, diabetes, and AIDS.

I salute Dr. Frankel and the City of Hope for their exemplary public service.

THE ''ERISA TARGETED HEALTH INSURANCE REFORM ACT OF 1995''

HON. HARRIS W. FAWELL

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 22, 1995

Mr. FAWELL. Mr. Speaker, last year reform of health care focused on what was wrong with the system. This year reform should be driven by what is working in the system and how we can expand on what is being done. Yesterday, I introduced the ERISA Targeted Health Insurance Reform Act. I also introduced a related bill, the Targeted Individual Health Insurance Reform Market Act which I will explain separately.

Joining as original cosponsors of the ERISA targeted bill are: My colleagues Representatives BILL GOODLING, DICK ARMEY, TIM PETRI, MARGE ROUKEMA, CASS BALLENGER, PETE HOEKSTRA, BUCK MCKEON, JAN MEYERS, JIM TALENT, JAMES GREENWOOD, TIM HUTCHINSON, JOE KNOLLENBERG, LINDSEY GRAHAM, DAVE WELDON, and DAVID MCINTOSH.

Our approach to fixing the problems—primarily lack of access to affordable coverage—is fundamentally different than that taken by the Clinton administration and Congress last year. In developing this legislation, we took the hippocratic oath: First, do no harm. We carefully target reforms to fix the problems without doing harm to the choice and quality of care enjoyed by most Americans. Moreover, we will not disturb the revolution in innovation and competition going on in the private sector—instead, we will build on it.

The legislation we are introducing addresses the problem areas in health care insurance: portability, preexisting conditions, and affordable coverage for small employers.

Most importantly, the framework builds on the successful and time-tested cornerstone of employee benefits law, the Employee Retirement Income Security Act [ERISA]. Under

ability and limits on preexisting conditions under health plans will help eliminate job lock. It gives increased purchasing power for employers and employees. Increased health plan competition will mean more affordable choice of coverage for many Americans.

Our legislation makes these targeted reforms without forcing Americans to give up their current coverage or restrict their choice of coverage—it should actually expand choice. Nor do we impose employer mandates, price controls, or a one-size-fits-all benefit package. Moreover, the legislation does not require any Government subsidies, expenditures, or taxes.

We have worked with many organizations in developing this legislation and have received a number of letters supportive of our effort to begin the debate on health insurance reform. So far, we have supportive letters from: the National Federation of Independent Business, the U.S. Chamber of Commerce, the ERISA Industry Committee, the National Association of Wholesalers, the National Association of Manufacturers, the Self-Insurance Institute of America, Associated Builders and Contractors, the Association of Private Pension and Welfare Plans, the National Business Coalition on Health, the National Retail Federation, the National Restaurant Association, Mutual of Omaha, and New York Life.

I've attached a section by section analysis of the first bill, the ERISA Targeted Health Insurance Reform Act, that has five subtitles (A through E). I will now explain what is contained in subtitles A and B. Subtitle A, entitled ''Increased Availability and Continuity of Health Coverage for Employees and Their Families'' deals with the subject matter of portability, limitations on preexisting condition exclusions, and private standard setting organizations. Subtitle B, entitled ''Requirements for Insurers Providing Health Insurance Coverage to Group Health Plans of Small Employers'' contains fair rating standards and rules relating to insurance availability in the small group market. After I've explained this, I will, at another time, explain subtitles C, D, and E.

THE ERISA TARGETED HEALTH INSURANCE REFORM ACT OF 1995

SUMMARY

The ERISA Targeted Health Insurance Reform Act of 1995 presents a well-targeted and workable framework within which incremental health insurance reform can be enacted this year.

The framework builds on the successful and time-tested cornerstone of employee benefits law set in 1974 under ERISA. Under the umbrella of ERISA, near ''universal health coverage'' has been afforded the employees of larger companies. It is long-overdue that cost-conscious small employers be given the opportunity to achieve the economies of scale and freedom from excessive government regulation and taxation that have been ERISA's hallmark. The problems of uninsured families can be strongly attacked by removing barriers and releasing the purchasing power of employers acting

saving innovations into the marketplace and into the 21st century.

In addition to addressing the problems of the uninsured and cost-control, the legislation contains important new protections and freedoms for workers who must compete in a more mobile workforce. No longer would covered workers face job-lock because they fear the lack of access to health insurance or denial of coverage because of a preexisting health condition.

The bill contains targeted but important elements of health insurance reform including participation, portability, renewability, utilization review, solvency, claims processing and fair rating standards.

The foundation of this bill, built upon ERISA, is to create an unfettered 21st century framework in which employers, employees, and their representatives are free to set the level of their health benefit promises and in which those promises will be better kept.

WHAT THE ERISA TARGETED HEALTH INSURANCE REFORM BILL DOES

New protections and freedoms for workers in a mobile workforce

Portability and limits on preexisting conditions under health plans helps eliminate job-lock (e.g. if an employee once chooses insurance coverage they do not have to again satisfy a preexisting condition as long as some form of coverage is continued).

Participation standards require annual open enrollment and limits exclusions based on certain age, service, and income criteria.

Insurers and multiple employer plans must guarantee the renewal of health coverage.

Increased purchasing power for employers and employees

Barriers are removed for employers to voluntarily form multiple employer health plans of the fully-insured and self-insured variety.

Barriers are removed to the formation of employer health coalitions enabling single and multiemployer plans to negotiate agreements with providers.

Let the market roar: Increased health plan competition means more affordable choice of coverage

State benefit mandates are limited.

State anti-managed-care laws are restructured and, instead, uniform standards are encouraged.

Restrictive state laws relating to Provider Health Networks, Employer Health Coalitions, insured plans, and self-insured plans are preempted.

Buyer cost awareness is encouraged through Medisave plans.

Access to fully-insured coverage expanded for employees of small employers

Insurers must open their small group (under 51 employees) markets to all eligible buyers.

Fair rating standards limit premium variations among similarly situated groups which balances the need to make insurance more affordable, but avoids ''sticker shock'' for the currently insured.

Increased consumer protections under ERISA plans

Claims processing and determinations must be timely and participant remedies are improved.

It does not impose employer mandates that result in lost wages and lost jobs.

It does not require any new federal spending or new taxes.

It does not have unfunded state or local mandates.

It does not have price controls or impose government-prescribed health care budgets that would lead to rationing or lower quality of care.

It does not establish a government-run health care system, nor does it create a massive bureaucracy.

It does not deny employers the right to self-insure, but does allow more employers to do so.

It does not impose a single, one-size-fits-all, national benefits package determined by the government.

Title I

Subtitle A—Increased availability and continuity of health coverage for employees and their families

The purpose of this subtitle is to expand access to affordable group health coverage for employers, employees, and their families and to help eliminate job-lock and the exclusion of such individuals from coverage due to preexisting condition restrictions.

Sec. 1001.—Access to affordable health plan coverage.

This section adds a new ERISA Part 8 providing for nondiscrimination, portability, renewability, and participation standards under Subpart A; encouragement of private standards—setting organizations for utilization review and provider networks under Subpart B; and standards and enforcement mechanisms applicable to insurers under Subpart C.

ERISA Part 8—Access and continuity of, Health Plan Coverage

''Sec. 800. Definitions and special rules.

Erisa Subpart A—Nondiscrimination, Portability, Renewability, and Plan Participation Standards

''Sec. 801. Nondiscrimination and limitations on preexisting condition exclusions.

''Sec. 802. Portability.

These sections of Part 8 of ERISA limit preexisting condition restrictions under all employer group health benefit plans, including self-funded plans. The same provisions also apply to health insurance coverage sold in the small group market. Section 8 provides that a child who is covered at birth or adoption and remains covered shall not be considered to have a preexisting condition at the time of birth or adoption.

The provisions will help end job-lock and assure continuous availability of health coverage by prohibiting preexisting condition restrictions for those who are continuously covered and elect coverage when first eligible. Coverage is considered ''continuous'' as long as any lapse in coverage is not longer than 3 months (6 months for employees who terminate employment). Generally, plans may not have more than a 3/6 preexisting exclusion (i.e. treatments or diagnoses in the 3 months prior to coverage could be excluded from coverage for up to 6 months). Insurers in the small group market can also offer 6/12 coverage.

''Sec. 803.—Requirements for renewability of coverage.

tion: (1) a waiting period beyond 90 days, (2) attainment of a specified age, (3) that an employee be highly compensated, or (4) that an employee perform more than a ''year of service'' as currently defined under ERISA. Employer contributions to a group health plan are not required.

An annual enrollment period of 30 days must be provided to enable employees to enroll in such coverage as provided under the terms of each group health plan. Employees and dependents may also enroll for coverage at the time of the loss of other coverage (if such coverage was the reason for declining enrollment when first eligible).

Subpart B—Encouragement of Private Standards Setting Organizations for Provider Networks and Utilization Review Under Group Health Plans

''Sec. 811.—Encouragement of private standards setting organizations for provider networks under group health plans.

''Sec. 812.—Encouragement of private standards setting organizations for utilization review under group health plans.

This Subpart B of ERISA encourages the establishment of private standards setting organizations to provide certain guidelines which would be applicable to provider networks under provider networks and toutilization review procedures under group health plans.

The standards which group health plans would look to from any such private entity would be related to (1) reasonably prompt access of individuals to covered services, (2) the extent to which emergency services are provided to individuals outside the provider network, (3) notification and review regarding the termination of providers from a network, and (4) conditions relating to utilization review, including timely review and provider participation in such decisions.

ERISA Subpart C—Establishment of Standards; Enforcement

''Sec. 821.—Establishment of standards applicable to insurers offering health insurance coverage to group health plans.

''Sec. 822.—Enforcement with respect to insurers offering health insurance coverage to group health plans.

''Sec. 823.—Preemption.

The standards applicable to group health plans under ERISA Subparts A and B are generally enforced under ERISA Part 5.

With respect to the standards applicable to insurers only, and not to group health plans, states may (in accordance with Sections 821 and 822) implement and enforce the nationally uniform standards under Subparts A and B, including the uniform regulations which may be recommended by the NAIC. States that voluntarily elect to implement such standards have the exclusive authority to enforce such standards as they apply to insurers and not to the group health plans which purchase health insurance coverage. In this fashion the traditional regulation of insurers by the states is preserved while the uniform regulation of group health plans under ERISA is not disturbed.

Pursuant to the preemption provisions under Section 823, a state may not establish or enforce standards applicable to insurers

to expand access to health insurance by making private health insurance coverage marketed to small employers more affordable and available regardless of an employee's health status and previous claims experience.

ERISA Subpart D—Requirements for Insurers Providing Health Insurance Coverage to Group Health Plans of Small Employers

''Sec. 831.—Definitions.

''Sec. 832.—Requirements for insurers to offer general, catastrophic, and Medisave coverage to small employers.

''Sec. 833.—General, catastrophic, and Medisave coverage defined.

These sections provide for the availability of health insurance coverage to all small employers from those insurers who sell health insurance in the small group market. Insurers would be required to open their general coverage market to small employers and to offer a catastrophic plan with higher cost-sharing provisions (unless the insurer is an HMO or does not otherwise offer fee-for-service coverage). Insurers may also offer a Medisave plan that includes catastrophic coverage with an integrated family medical savings account. Among the general policies offered must be a fee-for-service option, a managed care option, and point-of-service option, but only if these are made available by the insurer under other policies of insurance. Insurers must accept every small employer and every eligible employee of a small employer who applies for coverage under a plan as long as the plan meets the minimum participation requirements. The initial and annual enrollment periods of 30 days applicable to small group plans are identical to those applicable to all group health plans under section 804.

''Sec. 834.—Use of fair rating, uniform marketing materials, and miscellaneous consumer protections.

''Sec. 835.—Establishment of standards.

''Sec. 836.—Enforcement.

''Sec. 837.—Preemption.

Under these sections, insurers must use fair rating standards in setting initial and renewal premiums in the small group market. In general, premiums may vary for age, geographic area, family class, and administrative category for a particular benefit design. Discounts for employer wellness programs may also be given.

When the fair rating standards are first effective, the premiums of two employers having workforces with similar demographic characteristics cannot vary by more than 50% based on initial underwriting factors or in subsequent years, based on claims experience. This rule and the permitted one year surcharge for coverage containing the less restrictive 3/6 preexisting condition clause will help insulate currently insured employers for the premium ''sticker shock'' which could otherwise result from more restrictive rules. Suggestions as to the extent to which this 50% variation may be reduced over time without reducing coverage are solicited from the NAIC and other interested parties.

Such premium variations for individual employers participating in a qualified association which is experience-rated is not permitted.

Under sections 835 and 836 states may, but are not required, to implement and enforce standards with the uniform standards. After such period standards differing from the uniform standards are preempted under section 837.

Sec. 1102. Effective date.

In general the requirements of ERISA Subpart D apply on January 1, 1998 with regard to insurers offering health insurance coverage to small employers.

Subtitle C—Encouragement of multiple employer health plans and preemption

The purpose of this subtitle is to improve access to health coverage and lower insurance costs for both small and larger employers by encouraging the establishment of multiple employer purchasing arrangements, by eliminating costly state regulations, and by freeing market forces and creating a more competitive environment in which health care is delivered.

Sec. 1201—Scope of State Regulation

ERISA Subpart E—Scope of State Regulation

''Sec. 841—Prohibition of State benefit mandates for group health plans.

''Sec. 842—Prohibition of provisions prohibiting employer groups from purchasing health insurance.

''Sec. 843—Preemption of State anti-managed care laws.

These sections facilitate the ability of employers to form groups for the purpose of purchasing fully-insured health insurance coverage. The provisions will help reduce costly regulation and allow any group of employers to form any arrangement to purchase insurance. The preemption of anti-managed care laws is intended to allow market forces to operate to help contain health care costs.

Section 841 will also help lower costs, eliminate inter-state barriers, and provide a level playing field between insured and self-funded plans by eliminating burdensome and expensive state mandates. Although states could continue to mandate a comprehensive and basic benefit package, insurers would be free to design and offer employers and employees the type of coverage they want and can afford.

Sec. 1202—Preemption of state laws for Multiple Employer Benefits Plans meeting Federal Standards.

Part 7—Multiple Employer Health Plans

Sec. 701. Definitions.

Sec. 702. Exempted multiple employer health plans relieved of certain restrictions on preemption of State law and treated as employee welfare benefit plans.

Sec. 703. Exemption procedure.

Sec. 704. Eligibility Requirements.

Sec. 705. Additional requirements applicable to exempted multiple employer health plans.

Sec. 706. Disclosure to participating employers by arrangements providing medical care.

Sec. 707. Maintenance of reserves.

Sec. 708. Notice requirements for voluntary termination.

Sec. 709. Corrective actions and mandatory termination.

Sec. 710. Expiration, suspension, or revocation of exemption.

Sec. 711. Review of actions of the secretary.

exemption include certain collectively-bargained and ''single-employer'' plans that otherwise fail to meet criteria exempting them from the MEWA definition. Also certain employer associations, employee leasing arrangements, and provider health networks may also qualify. Arrangements receiving an exemption would be subject to uniform standards under ERISA regarding reporting, disclosure, fiduciary requirements, and new funding/reserve requirements. Regulations would be promulgated by the Department of Labor in connection with the standards. Arrangements operating multiple employer health plans would be required to notify the states in which they operate. In addition, new arrangements could not commence operations unless an exemption is obtained. Failure to follow this procedure would result in criminal penalties. States could enter into agreements with the Departmentregarding the enforcement of the federal statutory and exemption standards for exempted arrangements.

Sec. 1203—Clarification of scope of preemption rules.

Sec. 1204—Clarification of treatment of single employer arrangement.

Sec. 1205—Clarification of treatment of certain collectively bargained arrangements.

Sec. 1206—Employee leasing health care arrangement.

Sec. 1207—Enforcement provisions relating to multiple employer welfare arrangements and employee leasing health care arrangement.

Sec. 1208—Fling requirements for multiple employer welfare arrangements providing health benefits.

Sec. 1209—Cooperation between Federal and State authorities Sec.

Sec. 1210—Clarification of treatment of employer health coalitions.

Sec. 1211—Single annual filing for all participating employers.

Sec. 1212—Effective date; transitional rules.

Subtitle D—Remedies and enforcement with respect to group health plans

This subtitle includes provisions for expediting the claim process and clarifying the remedies available in the case of claims disputes under ERISA group health plans.

Sec. 1301.—Claims procedures for group health plans.

This section expedites the claims process under ERISA health plans by requiring that claims for medical benefits be approved within 45 days of the filing completion date. A full and fair review must also be provided within 45 days of the review filing date. Requests for emergency preauthorization must be provided within 10 days (or 48 hours in the case of extreme emergencies), with the opportunity for a full and fair review of each within the same time period for approval. The same time frames for approval and review would apply to requests for utilization review determinations and emergency utilization review determinations.

Sec. 1302.—Available court remedies.

This section amends Section 502 of the Employee Retirement Income Security Act of 1974 (ERISA) to provide for the following court remedies in the case of a plaintiff prevails in a claim for benefits: (1) a cease and

The amendments to ERISA in this Subtitle take effect January 1, 1998.

Subtitle E—Funding and plan termination requirements for self-insured group health plans

Sec. 1401.—Special rules Self-Insured Group Health Plans.

This section adds a new section 610 to ERISA Part 6 providing for plan termination and funding requirements for certain plans. Under subsection 610(b) the single-employer self-insured group health plans maintained by small employers are required to establish reserves in an amount equal to 25% of expected annual incurred claims and expenses or the estimated amount of incurred, but unpaid, claims, if greater. Alternative means of meeting such requirements would take into account factors such as the size of the plan, the benefit design, the presence of stop-loss coverage, and either security, guarantee, or financial arrangements. The self-insured plans maintained by large plan sponsors who meet certain distress criteria would also have to file notice and a financial plan demonstrating the basis for the continued timely payment of benefits. A safe-harbor for large plans meeting the above described reserve requirements for small plans would be provided, thus obviating the need to file such a notice in the event of the distress of the plan sponsor. Multiemployer plans would have to maintain contributions and assets at a level so as to avoid becoming financially overburdened.

New ERISA section 611 spells out the requirements for notice and procedures related to the voluntary termination of self-insured plans and to the mandatory termination by the Secretary of Labor of such plans in the event of their failure to meet reserve or other requirements.

Sec. 1402.—Effective Date.

Section 610 applies to plan years beginning on or after January 1, 1998.

WITH NEW NAACP LEADER WE CAN HAVE HOPE

HON. CARDISS COLLINS

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 22, 1995

Mrs. COLLINS of Illinois. Mr. Speaker, the selection this past weekend by the National Association for the Advancement of Colored People [NAACP] of Myrlie Evers-Williams as its new chairwoman, comes at a crucial time for new and aggressive leadership of our Nation's oldest civil rights organization.

I congratulate Mrs. Evers-Williams, and I salute the NAACP for its courage in making tough choices. Tough choices are never easy to make, and I doubt if this will be a choice made in vain.

Mrs. Evers-Williams now has before her the immediate task of protesting G.O.P. roll-backs of civil rights gains spearheaded by her organization over the past three decades. These are civil rights policies—labeled affirmative action programs—that have been set in place in

males.

On the west coast—in California—voters who last year denied services to illegal immigrants, were gearing up to decide whether to end State programs that broaden opportunities for those most in need—women and racial/ethnic minorities.

How symbolic that such battles are taking place during Black History Month. How frightening that these battles must take place again—or even at all.

I stand with our freedom fighters willing to continue the struggle for civil rights for all Americans. Indeed, anyone who has benefited from these rights is obligated to rise today to ward off this vicious, mean-spirited attack against our hard fought gains.

Mr. Speaker, listen to the message being delivered to America today. The people want opportunity. The people want freedom of choice. Don't allow roll backs of the struggles for civil rights. Let this great Nation of ours continue becoming even greater. In other words, leave our civil rights gains alone.

FCC TAX CERTIFICATE PROGRAM

HON. BILL RICHARDSON

OF NEW MEXICO

IN THE HOUSE OF REPRESENTATIVES

Wednesday, February 22, 1995

Mr. RICHARDSON. Mr. Speaker, yesterday the House unwisely voted to eliminate the Federal Communications Commission's tax certificate program to encourage minority ownership of telecommunications entities. This program has successfully allowed minorities to add their voice to society through our Nation's vast array of communications media. All Americans must have access to the means of communication and FCC's tax certificate program ensures diversity of content. My friends at the Minority Media and Telecommunications Council have put together a list of 14 points on the importance of this program. I urge my colleagues on the House and Senate side to consider the following points.

WHY THE FCC'S TAX CERTIFICATE POLICY SHOULD BE RETAINED

1. The policy benefits taxpayers. By involving otherwise excluded minorities in media ownership, more broadcast and cable properties reach their highest valued use, thereby creating jobs and generating investment and tax revenues. The policy's reinvestment feature retains capital in the media industries, where it helps build the communications infrastructure. Furthermore, the policy helps minority business succeed and ultimately become taxpayers.

2. The FCC was justified in adopting the policy in 1978. It had before it an extensive staff report documenting the need for minorities to participate in the broadcasting industry as owners, and the need for marketplace intervention to help achieve that objective. The Reagan FCC supplemented that record in 1982. Even when the Commission

4. The policy is consistent with the original intent of Section 1071, and with the Commission's interpretation of Section 1071. Congress gave the Commission wide discretion in the implementation of Section 1071. In applying Section 1071 to other diversity-promoting contexts, the Commission exercised its discretion with Congressional endorsement. The Commission followed the same procedures in using tax certificates to promote minority ownership.

5. The policy has delivered important benefits to the public. Extensive research cited in *Metro Broadcasting, Inc. v. FCC,* 497 U.S. 547, 579–84 (1990) demonstrates that the minority ownership promotes diversity in service to the public. Minority owners are industry leaders in hiring and training minorities, and in providing information which is unavailable from other outlets. The policy has delivered value far beyond the public's investment.

6. The policy evolved as a highly desirable substitute for intrusive content-based regulation. Any weakening of the policy will severely undermine—and could prompt reexamination—of the FCC's reliance on its minority ownership policies as a substitute for content-based regulation in promoting First Amendment values.

7. The policy is fair. It has never been seriously accused of disadvantaging whites, since it is neither a quota nor a set aside.

8. The policy is very cost effective. It goes to the heart of the problem—access to capital. Moreover, it is very inexpensive to administer.

9. The policy is especially valuable to the cable industry. Cable operators possess unique power to select the range of programming available to viewers and to stimulate diversity in the national programming marketplace. Thus, diversity in cable ownership is especially critical to cable viewers.

10. Weakening the policy would make it commercially irrelevant. The policy's incentive to sell properties to minorities is only moderate, having been primarily responsible for increasing minority broadcast ownership from almost zero to 2.7% in 15 years. That is very significant but hardly indicative of a massive rush by sellers to trade with minority buyers.

11. The policy should be applied to transactions regardless of size. The policy was designed to help minorities enter the mainstream of American commerce. While tax certificates have been primarily used for small transactions, one might occasionally be used for a larger transaction, given the growth in the communications industry. Because other companies had such a long headstart in spectrum access and media ownership, no minority broadcaster or cable system owner has yet attained sufficient size and influence to justify ''graduation'' out of the program.

12. Third parties have a fair chance to challenge applicant bonafides. In questions from the bench in *Adarand Constructors v. Peña,* No. 93–1841 (argued January 17, 1995), Justice O'Connor expressed concern that third parties should have a meaningful opportunity to challenge specific transactions. The FCC's well established petition to deny process affords challengers that right. Indeed, abuses